Good afternoon. We appreciate your sharing of the draft standards of certification for Patient-Centered Medical Homes. In general, the standards and related definitions seem comprehensive and reflective of PCMH objectives. The following are a few comments or clarifications that we noted in reviewing the standards and related definitions:

- With reference to the **Care Coordination** standard, it does not seem that including family and caregivers in proactively managing "all aspects of preventive and chronic care" has been sufficiently represented under the Definitions, except in a limited way under the "Optimal" Pathway level. The role of family and caregivers is so important, especially for patients with complex and/or chronic conditions, that we would ask whether the definitions could provide language to incorporate this important role to a greater extent and at a minimum to do so under the Advanced as well as Optimal levels.

- Concerning **Enhanced Access & Communication**, we agree that optimizing timely access to appropriate services is appropriate for all Pathway levels. It was not clear to us, in the definition under the Basic level, if practices would have to commit to expanded office hours evenings/week-ends for patients, even for routine and/or preventive care, … and not just rely on alternative modes of clinical consultation (i.e., telephonic, electronic) or Urgent Care Centers.

- On the **Resource Stewardship** standard, we would propose that tracking over/under utilization and implementing waste reduction initiative/s/ are integral to care transformation and payment reform and, as such, should be reflected under the "Basic" Pathway level.

We would be happy to answer any questions you have on these comments. Thank you.

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